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ABSTRACT

Twelve priority areas for health education in the 1980s are identified, based on the magnitude and seriousness of the problems addressed; the solidity of the research base; and the likelihood that health education may facilitate improvement in the area. The twelve areas are: (1) cigarette smoking; (2) aging and the aged; (3) mental health; (4) violence (car accidents, suicide, homicide); (5) nutrition; (6) job-related hazards and risks; (7) use of medical resources; (8) childhood immunizations; (9) healthy births; (10) comprehensive school health education; (11) bias and discrimination; and (12) wellness education. (JD)

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PRIORITIES FOR HEALTH EDUCATION*

by

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* Keynote Address at the Fall 1982 Initiation of the Alpha Alpha Chapter of Eta Sigma Gamma.

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In a 1970 address to the American School Health Association annual meeting in Houston, Texas, John Sinacore identified a set of priority areas for school health education.[1] As we advance into the 80's it seems to me that we are due for a reexamination of our priorities in health education.

It is my intention to identify twelve priority areas for health education in the 80's. This is, of course, only one man's view. And, just as John Sinacore's listing was a school health educator's listing, these are priorities as seen through the eyes of a community health educator and may be colored or distorted thereby. The priorities are not offered in any ranked ordering but are merely presented as twelve areas worthy of emphasis in our efforts over the next decade.

In identifying priority areas I have endeavored to consider three criteria: 1) the magnitude and seriousness of the problems addressed, 2) the solidity of the research base for our efforts, and 3) the likelihood that health education can do some good.

The first priority that I identified was <u>cigarette smoking.</u> Cigarette smoking is the leading cause of preventable deaths in the United States.[2] It has been identified as a major cause of four of the five leading causes of death -- heart disease, cancer, accidents and pneumonia/influenza. On our campus cigarette smoking has been found to be a major correlate of the frequency of student illnesses.

Since the Surgeon General's 1964 report on <u>Smoking and Health</u> many Americans have given up smoking. Fewer boys are taking up the habit.

But among women, and especially among teenage girls, smoking is on the increase. We have seen that impact on this problem is possible, our partial successes show this, but there is still a long way to go.

A second priority area is aging and the aged. A quarter of a century ago 8% of the U.S. population was aged 65 or older. Today, close to 11% of our population, or 23 million people, are at least 65 years old. Within that age group the population group over age 75 is growing most rapidly.

Educating the aged regarding ways to maintain and emhance their own health is only part of the challenge facing health educators. Equally challenging is the task of teaching the rest of our society about aging and the problems of the aged while dispelling the myths about aging which are so prevalent.

A third priority area is mental health. About twenty-five percent of the U.S. population suffers from a mental health problem -- including about 20 million diagnosable psychotics or neurotics, 10 million problem drinkers, and 25 million abusers of drugs other than alcohol.[3] More than half of the U.S. health care expenditures go for mental health services.

Education about drugs, about stress, about coping skills, etc. could, it seems reasonable to believe, reduce the incidence of mental health problems.[4] At the same time, the public needs to be educated about mental health. In this area too the myths are more prevalent than factual knowledge.

Fourth is violence. Accidents are the fourth leading cause of death in the U.S., suicide is seventh and homicide is ninth. Death

rates in general have been going dow since the turn of the Century, but the suicide rate is up 10% and the homicide rate is up 1,010%.[5] Death rates had been going down for every age group in the U.S. until the last two decades, but over the past twenty-two years the death rate among 15-24 year olds has increased by 1.2 to 1. % per year. This increase has been mainly due to increases in violent deaths, especially suicide. Among non-White youths this increase has been even greater.

Educational efforts aimed at discouraging handgun ownership, discouraging drunkenness, encouraging seat belt usage, etc. all would have potential for reducing violence. Here again there is a great need for dispelling myths. Virtually every widely accepted "fact" about violence is a myth and we can never succeed in reducing violence as long as our social policies continue to be based on myths.

Fifth is nutrition. Nutritional myths may be even more pervasive than those about aging, mental health or violence. As a society we waste millions of dollars each year on vitamin supplements few of us need and none of us should need. At the same time it seems that we don't eat enough vegetables and eat too much meat and too much salt.

We need to teach the simple, solid, proven facts about nutrition while debunking the numerous myths. Also, we must not forget that some of these myths are quite prevalent among health educators.

The sixth priority is the area of job-related risks. During World War II more Americans were killed or crippled while working in the factories here in the U.S. than while fighting in our armed forces overseas. Occupational exposures to accident risks, to carcinogens, to dusts, etc. continue to be major causes of morbidity and mortality in the U.S..

So far most "industrial health education" programs seem to be

exercise/fitness programs. I don't deny the value of these programs but it seems to me that they are missing the mark on what industrial health education ought to be about. We need to develop programs that are relevant to the job-related risks which are all too common in the workplace.

Seventh is education regarding use of medical resources. Our society's use of medical resources is far from the rational model we might hope for. Some overuse medical and hospital care, some are afraid to go to a physician, some waste time and money on quacks and nostrums when they need medical treatment that is available, and many having gone to a physician then fail to follow the physician's instructions.

At least in part this is a problem of the medical mystique. People don't know what to expect of a physician and often expect too much. They see the physician as too nearly omnipotent and fear putting themselves into the care of these omnipotent ones lest some awful secret be seen. When they do go to the physician they expect that omnipotence to produce a quick and certain cure. They want the physician to do something to them to "make them well", not to tell them that they must do something for themselves.

We must educate the public to be rational consumers of medical care. They must be educated to become active participants in their own medical care rather than passive recipients. This can be done, but so far we have done little of it. Even where we have patient education programs in place the emphasis is often on explaining more fully the physician's instructions not on helping the patient to become an active partner in decision-making.

The eighth priority area is childhood immunizations. Immunization against the major childhood diseases is one of the simplest, safest, surest and most cost-effective of all preventive measures. Nevertheless, thirty to forty percent of our nation's children under five lack one or more of the immunizations recommended for their age against diptheria, measles, pertussis, polio, rubella or tetanus. Less than half are immunized against mumps -- a funny little disease capable of producing some very unfunny or even fatal consequences. Despite this, the current federal administration is cutting back on immunization programs.

It is vitally important that health educators work to inform the public about the continuing need for childhood immunizations. We must maintain public support for strict enforcement of regulations requiring immunizations for school attendance. We must gather public support to restore funding cut from immunization programs.

Ninth is healthy births. We have made great strides in forwarding family planning so that more of our society's newborns are wanted and loved. Of course, we must continue these efforts. But we still have too many babies born with low-birth-weights or with congenital defects. Seven percent of all newborns are low-birth-weight and they account for 75% of all neonatal deaths.

Health education has only a part of the answer to these problems but we can do our part. We can help by teaching mothers-to-be about maternal nutrition, exercise, smoking and drinking. We need to address ourselve to fathers-to-be also, for we are learning that the father's smoking and drinking may also impair the infant's eventual well-being.

The tenth priority I identified was comprehensive school health education. You may be surprised to find school health education on a community health educator's list of priorities, but school health education is in trouble and we must all come to its aid. The Office of Comprehensive School Health Education no longer exists in the U.S. Department of Education -- and who knows how much longer the Department itself will survive. Health Education mandates are under attack in many states. Here in Illinois the two alternatives under consideration by our state Board of Education essentially amount to a choice between doing away with health education this year or three years from now.

We must fight to keep the gains we so recently fought to acquire. The public must be aroused about this issue. School health education must become a major topic for community health education.

The eleventh priority is 'isms. Racism, sexism, chauvinism, ageism are all contributory causes of much of the morbidity and mortality in our society. If we all should fall prey to the "final epidemic" of nuclear war it will be these 'isms that must bear the bulk of the blame.

As health educators we must give a priority to the elimination of these divisive 'isms. We will never succeed in any of our other priorities without giving attention to this vital priority.

The twelfth and final priority I identified was wellness. Health education is the name of our profession, not disease education or risk factor education. Our goal should be something more than just absence of disease. Call it what you will -- wellness, orthosis, positive health, or just plain health -- but don't get lost in the medical model and forget it.

Probably these aren't the twelve areas you would have chosen as the priorities for health education in the 80's. Fine; I never said they would be. What I did hope to do was to encourage you to think about priorities. I hope that in this I have succeeded.

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